UBO New Horizon

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Introduction

- Workload Standardization Billing Implications
- New Rates
- Long Range Implication of 32 Legislative changes

Workload Standardization Billing Implications

Purpose

To provide an interim method for collecting workload and expenses for various healthcare encounters and services.

Goals

- By October 1, 1999 begin to capture IP provider workload
- Minimize impact to computer systems and personnel
- Align DoD’s workload and coding closer to civilian practices

SIDR and SADR

- **Currently**
  - One SIDR is created for each IP stay
  - One SADR is created for each OP visit

- **October 1, 1999 DoD will begin to capture inpatient provider visits in ADS.**
  - One SIDR for each IP stay
  - Multiple SADRs for an IP stay

Data Collection

- **Inpatient stays**
  - CHCS collects the stay information and will create a SIDR
  - ADS collects the provider visit information and will begin to create a SADR for each provider encounter
- **Outpatient visits**
  - ADS collects all the workload information needed for APGs and provider visit information

Use of SADRs

- **SADR** should be created if a provider performs a patient service of sufficient substance that it should be documented in the patient record.

Except for:

- Non-clinician and ancillary personnel working routinely in the patient setting (***their Workload is captured in the DRG)***
- Provider groups (such as Grand Rounds for educational purposes)

Workload

- Workload will be counted separately for both the facility and the provider.
  - Facility workload
    - Inpatient workload - RWP and DRG
    - Outpatient workload - APG
  - Provider Workload
    - E/M and CPT codes and HCPCS RVUs

Provider Workload

(Physician labor)

- Begin to capture a total count of provider workload in both the IP and the OP arena.
  - All provider CPT and HCPCS data captured in ADS.
  - ADS bubble sheet must be coded as “IP”.
    - ADS does this automatically if CHCS is used to create the appointment for an IP
    - Not a “count” visit, though a SADR is created

Facility Workload

All other material, labor overhead and supporting costs associated with patient service.

- DRG for Inpatients
- APG for Outpatients

Use of CPT & HCPCS

- **DoD will follow civilian coding standards.**
  - All CPT codes should be recorded as they occurred, regardless of whether the provider was a physician
  - Codes should be used in their normal meaning as found in CPT codebook references

Pseudo-Providers

- Due to system constraints DoD will

  begin to identify certain care settings

  by the use of “Pseudo-Providers”.

Pseudo-Providers

Must be included in the CHCS Provider Table prior to their use

Provider ID	Provider Name	Provider Specialty Type	
000-00-0011	Home Health	600	
000-00-0022	Telemedicine Consultant		600
000-00-0033	Telemedicine Initiator		600
000-00-0044	External Facility		600
000-00-0055	External Provider	600	

cont.

- **Home Health -** a care provider visits a

  home to assess suitability of the environment for the provision of health care services or to provide care.

cont.

- **Telemedicine Consult** - A provider at one facility responds to a provider at a distant facility who requests documented consultation (non-ancillary diagnosis, prognosis, and or treatment regimen guidance.)
- **Telemedicine Initiator** - A provider, co-located with the patient, requests and receives documented consultation (non-ancillary diagnosis, prognosis, and or treatment regimen guidance) from a consultant at a distant facility.

cont.

- **External Facility -** A DoD provider submits

  a SADR to his/her own ADS system reporting the rendering of health care services to a patient at a facility other than the one to which the provider is assigned. The provider is not on loan to that facility.

cont.

- **External Provider** - A DoD provider completes two ADS Encounter Forms to report that he/she rendered health care services at a facility

  other than the one to which he/she is assigned. One ADS Form is scanned at his/her assigned facility to capture the provider costs and the seconds ADS

  Form is scanned at the facility where services were performed to document institutional costs. The provider was not on loan to this facility.

Special Cases

Workload Credit Facility	Provider	
Home Health	CPT	APG
Telemedicine Consultant	CPT	------
Telemedicine Initiator	CPT	APG
External Facility ------		APG
External Provider	CPT	------

Provider Table

Each Clinic or Service must be

linked to the appropriate pseudo- provider in the CHCS Provider

Table.

Provider Table

- All genuine providers in the provider table must be updated to reflect a specialty type that includes a skill leve

- Currently, CHCS has a variety of "placeholder" specialty types (e.g., orthopedics) which does not indicate a skill level (e.g., orthopedic surgeon).

Special Care

- **Identified by using Admitting MEPRS code**

Special Care Type	MEPRS
Hospice Care	AZA
SNF-level Care	AZB
Minimal Care	AZC
Observation Care*	AZD
Combined Non-Hospital Care	AZX

cont.

- Used mainly as a way to flag the care
- Can be used as a flag or ***can*** establish a cost center if you want to staff a separate area
- Not an InterQual qualified admission

New Potential Rates

Separate APV rate for certain clinics may be possible for FY00

Future years (issue paper needs to be submitted)

- Trauma
- Dialysis
- Chemotherapy
- Helicopter transport

Legislative

Transition To Itemized Patient Billing, New Rates Based On Reasonable Charges Such As

CMAC

Evaluate And Test The Impact Of The New Rates on Reimbursement

Comparison to prior rates based On reasonable costs

Define Areas Of Impact

- Systems
- Forms
- Manuals
- TMA/Service policies, guidelines

System Change Issues

- Funding
- Development
- Testing
- Implementation

Define Necessary SCRs For MHS Systems

- TPOCS
- CHCS
- EAS
- CEIS
- ADS

Training/Communication

- Users
- Providers
- Payers